Tobacco

Position statements

- The College is serious about helping reduce smoking rates.
- The College supports increasing the excise tax on tobacco as one of the measures to reduce the prevalence of smoking in New Zealand and believes further increases must be made. The College also believes most of the extra income from tobacco tax must be dedicated to cessation programmes especially targeting low-income earners, MŪori and Pacific smokers, at-risk youth and patients with chronic illnesses.
- The College supports Government introducing plain packaging of tobacco products and urges it to follow the lead set by the Australian Government.
- The College supports programmes and initiatives that involve general practices and their patients in smoking cessation. General practices are encouraged to increase their use of the ABC approach and aim to ask every smoker about quitting at every visit. Practices should also be supported to use audits to know where improvements need to be made.
- The College strongly supports equitable and effective measures to reduce smoking rates among MŪori.
- The College supports making New Zealand smoke-free and advocates for this to occur as soon as possible, with specific targets for MŪori.
- The College supports government following the lead of other countries by passing legislation to ban smoking in cars that are carrying children.
- The College supports introduction of a tobacco retailer register in line with best practice.

More than one in five New Zealanders smoke tobacco regularly.[1] In New Zealand, the average age that 15ï 19-year-olds had their first cigarette is 13.3 years of age.[2] Half of people under 18 who smoke have tried to quit and two-thirds express regret at having started. Eight out of ten (80 percent) of current smokers aged 15ï 64 years said that they would not smoke if they had their life over again.[3]

Around 5000 premature smoking-related deaths still occur in New Zealand every year, both as a consequence of active smoking and through exposure to second-hand smoke. Half of these people die in middle age, losing 13 to 15 years of life on average.[4] Smoking causes around 85 percent of lung cancers, the leading cause of cancer death in New Zealand, and is linked to many other types of cancer. It is a major cause of heart attacks, strokes, other cardiovascular diseases, serious respiratory diseases, such as emphysema, bronchitis and asthma, and also a range of other conditions including blindness and infertility.[5] Exposure of second-hand smoke in children is linked to middle ear infections, lower respiratory illness, onset of

[1] Ministry of Health. 2009. Tobacco Trends 2008. Wellington: Ministry of Health.
[2] Ministry of Health. 2009. Tobacco Trends 2008. Wellington: Ministry of Health.
[3] Ministry of Health. 2010. Tobacco Use in New Zealand: Key findings from the 2009 Tobacco Use Survey.
[4] Brinson D. 2009. How to increase the delivery of effective smoking cessation treatments in primary care settings: guidance for doctors, nurses, other health professionals and healthcare organizations. Wellington: MOH and HSAC, University of Canterbury.
[5] Government response to the report of the MŪori Affairs Committee on its inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for MŪori, 2011.

asthma, reduced lung growth and sudden unexplained death in infancy.[6] Quitting smoking has immediate health benefits: it reduces the risk of diseases caused by smoking and improves general health and wellbeing.[7]

The prevalence of current smokers varies considerably by ethnicity. The prevalence of smoking among MŪori continues to be high (46 percent) and the prevalence of smoking among Pacific people is also high (36 percent), compared with Asian people (12 percent), and European/other ethnic groups (20 percent).[8]

MŪori in all age groups have much higher smoking rates than non-MŪori ï more than twice as high as the rest of the population. MŪori women (49 percent) have higher smoking prevalence than MŪori men (40 percent).[9] Lung cancer affects MŪori at nearly twice the rate of non-MŪori. Similarly, MŪori die at twice the rate of non-MŪori from heart disease and stroke and three times the rate from lung disease,[10] all of which reflects greater smoking rates among MŪori.

The decline in smoking rates among MŪori has lagged behind that of non-MŪori. As a result, the burden of illness (death, disease, reduced health status, and loss of social, economic and cultural opportunities) has fallen disproportionably on MŪori. A significant proportion of the disparities in health seen between MŪori and non-MŪori may be accounted for by differences in smoking prevalence in these groups.[11]

Excise tax

The evidence strongly supports taxation as an effective mechanism for encouraging more smokers to quit.[12] The recent tax increases on tobacco in New Zealand have resulted in more smokers making an attempt to quit smoking and more smokers identifying cost as a motive for quitting.[13] Increasing excise tax on cigarettes is one of the most powerful tobacco control interventions because it results in a reduction in smoking initiation in youths, an increase in quit attempts made by smokers and a reduction in consumption of cigarettes for young adult smokers. A 10 percent increase in tax on tobacco has an estimated 5-8 percent reduction in smoking prevalence, and this effect is even greater for young people, being more price sensitive than adult smokers.[14]

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[6] Public Health Advisory Committee. 2010. The Best Start in Life: Achieving effective action on child health and wellbeing.

[7] Ministry of Health. 2010. Tobacco Use in New Zealand: Key findings from the 2009 Tobacco Use Survey.

[8] Brinson D. 2009. How to increase the delivery of effective smoking cessation treatments in primary care settings: guidance for doctors, nurses, other health professionals and healthcare organizations. Wellington: MOH and HSAC, University of Canterbury.

[9] Government response to the report of the MŪori Affairs Committee on its inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for MŪori, 2011.

[10] Robson B and Harris R (eds). 2007. Hauora: MŪori Standards of Health IV: A study of the years 2000ï 2005. Wellington: Te Ropu Rangahau Hauora a Eru Pomare.

[11] Brinson D. 2009. How to increase the delivery of effective smoking cessation treatments in primary care settings: guidance for doctors, nurses, other health professionals and healthcare organizations. Wellington: MOH and HSAC, University of Canterbury.

[12] Ministry of Health. 2011. Targeting smokers better help for smokers to quit.

[13] K MacFarlane et al. 2011. Tax as a motivating factor to make a quit attempt from smoking: a study before and after the April 2010 tax increase. Journal of Primary Health Care, December 2011.

[14] K MacFarlane et al. 2011. Tax as a motivating factor to make a quit attempt from smoking: a study before and after the April 2010 tax increase. Journal of Primary Health Care, December 2011.

The College supports increasing the excise tax on tobacco as one of the measures to reduce the prevalence of smoking in New Zealand and believes further increases must be made. There are concerns that a tax increase will hit low income and, in particular, MŪori and Pacific smokers hardest. These are important and valid concerns. However, there is evidence that those who spend a greater proportion of their income on tobacco are most responsive to reducing consumption after a price increase and cessation resources should be weighted towards these communities.

The long-term gains expected from reduced smoking far outweigh the short-term hardships. Short-term hardships could be countered with appropriate measures in place, such as active support around budgeting and small financial grants. In our view, an important part of making this strategy work would involve dedicating most of the extra tax income from tobacco to cessation programmes, especially targeting low-income earners, MŪori and Pacific smokers, at-risk youth and patients with chronic illnesses whose health is further compromised by smoking. Anecdotal evidence from the wider community suggests that the public, including current smokers, would be supportive of the revenue generated from increased taxation to be used to help smokers quit.

Plain packaging

There are strong grounds for believing that current packaging glamourises smoking and that tobacco products packaged in a standardised colour, typeface and form would:

- improve the effectiveness of health warnings
- reduce misconceptions about relative harmfulness of various brands
- reduce the overall appeal of smoking.[15]

The College therefore supports Government introducing plain packaging of tobacco products and urges it to follow the lead set by the Australian government.

Interventions in general practice

There is strong evidence that brief advice from a health professional is highly effective at encouraging people to try to quit smoking, and to stay smoke-free.[16] Increased quit attempts are linked with providing cessation services and ógearly brief interventionô by health professionals.[17] Evidence also suggests that a ópersonalised brief advice letter from a patientôs GP plus a voucher for one monthôs nicotine gum appeared to prompt an increase in quit attemptsôand óif scaled up, this strategy has the potential to reach a large number of smokersé in particular population groups with a high burden of smoking-related illnessô If appropriately resourced and purposefully targeted, this strategy could complement other programmes to reduce the prevalence of smoking in New Zealand.[18]

Despite the known cost-effectiveness of patient-level smoking cessation treatments, a common finding from international health services research is that many patients

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[15] Quit Victoria, Cancer Council Victoria. 2011. Plain packaging of tobacco products: a review of the evidence.

[16] Ministry of Health. 2011. Targeting smokers better help for smokers to quit.

[17] Public Health advisory Committee. 2010. The Best Start in Life: Achieving effective action on child health and wellbeing.

[18] Watson D et al. 2010. Impact on quit attempts of mailed general practitioner óbrief adviceô letters plus nicotine replacement therapy vouchers. Journal of Primary Health Care.

do not receive these treatments. Many studies of the delivery of smoking cessation interventions in primary care settings suggest that opportunities to intervene are very often missed.[19] The results from the 2009 Tobacco Use Survey show that, of those who had seen a GP in the previous 12 months:

- nearly half (46 percent) of all 15ï 64-year-olds and approximately seven in 10 current smokers (70.4 percent) reported that a GP had asked if they had ever been or currently were a smoker
- significantly fewer 15ï 19-year-olds were asked if they had ever been or currently were a smoker than all of the older age groups
- nearly one-third (30.9 percent) of 15ï 64-year-old current smokers were provided with quitting advice or information and referred to quitting programmes or given quitting products
- of those current smokers, those in the younger age groups (15ï 19, 20ï 24 and 25ï 29-year-olds) were significantly less likely to have been provided with quitting advice or information and referred to quitting programmes or given quitting products by a GP than older people aged 40ï 49 and 50ï 59 years
- those aged 30ï 39 were less likely to have been provided with quitting advice or information and referred to quitting programmes or given quitting products by a GP than those aged 40ï 49 years old
- nearly three in 10 (29.1 percent) 15ï 64 year-old current smokers were provided with all three components of the ABC approach.[20]

The Ministry of Health has set a health target indicator for primary care that 90 percent of enrolled patients who smoke and are seen in general practice will be provided with advice and help to quit by July 2012.

In 2012/13 an additional indicator will include progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with a lead maternity carer are offered advice and support to quit. To meet these targets, general practices will need to aspire to having the smoking status of all patients recorded and encourage every clinician to ask every smoker at every visit about quitting.[21] General practice teams should include a focus on smoking cessation for pregnant women as a child protection activity.

The College supports quit-smoking programmes and initiatives that directly involve general practices and their patients. General practice teams are strategically positioned to maximise quit-smoking initiatives, such as prescribing and distributing nicotine products and setting up support groups. However, these incentives and interventions should be cost-neutral to the patients and easily accessible to them.

One of the indicators from *Aiming for Excellence* (the quality standard for general practice) is about the practice routinely identifying people who smoke and offering interventions. To meet the standard practices must:

- record the smoking history and status of newly enrolled patients 15 years and over

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[19] Brinson D. 2009. How to increase the delivery of effective smoking cessation treatments in primary care settings: guidance for doctors, nurses, other health professionals and healthcare organizations. Wellington: MOH and HSAC, University of Canterbury.

[20] Ministry of Health. 2010. Tobacco Use in New Zealand: Key findings from the 2009 Tobacco Use Survey.

[21] Brinson D. 2009. How to increase the delivery of effective smoking cessation treatments in primary care settings: guidance for doctors, nurses, other health professionals and healthcare organizations. Wellington: MOH and HSAC, University of Canterbury.

- actively promote smoking cessation strategies and provide educational intervention programme information to patients
- have access to external programmes that help patients with smoking cessation
- routinely update the current smoking status of patients.

This may require an identified individual(s) in the practice running the smoking cessation programme and may have workforce and training implications.

Aiming for Excellence promotes use of the ABC approach from the New Zealand Smoking Cessation Guidelines. This provides prompts to:

- **A**sk about smoking status
- give **B**rief advice to stop smoking to all smokers
- provide evidence-based **C**essation support to those who wish to stop smoking.

General practice teams are encouraged to give brief advice to stop smoking to all people who smoke, regardless of whether they say they are ready to stop smoking or not and should provide evidence-based cessation support for those who express a desire to stop smoking.[22] Another important issue for general practices is audits related to patient smoking. Audits allow clinicians to measure their progress and celebrate their successes and plan for improvements.[23]

Equity for Māori

A greater reduction in smoking prevalence in MŪori, compared to non-MŪori, would close the inequalities gap.[24] The College strongly supports equitable and effective measures to reduce smoking rates among MŪori. In particular, measures such as increasing tobacco taxes, strengthening targeted social marketing programmes and targeted quit programmes should be considered for implementation. Smoke-free environments could be further promoted and measures taken to reduce the advertising of tobacco. Having support tailored specifically for MŪori and people of low socioeconomic status is important because these groups have higher smoking rates.[25]

Smoke-free New Zealand

The College is a member of the Smokefree Coalition and has endorsed its strategy, Tupeka Kore Aotearoa 2020 ï Tobacco Free New Zealand 2020, which has a vision ñthat future generations of New Zealanders will be free from exposure to tobacco products and will enjoy tobacco-free livesò Blakely, Simmers and Sharpe have estimated that making New Zealand smoke-free, compared to 2006 smoking rates continuing unabated into the future might result in five years in life expectancy for

[22] The Royal New Zealand College of General Practitioners. 2011. Aiming for Excellence 2011-2014.
[23] Brinson D. 2009. How to increase the delivery of effective smoking cessation treatments in primary care settings: guidance for doctors, nurses, other health professionals and healthcare organizations. Wellington: MOH and HSAC, University of Canterbury.
[24] Brinson D. 2009. How to increase the delivery of effective smoking cessation treatments in primary care settings: guidance for doctors, nurses, other health professionals and healthcare organizations. Wellington: MOH and HSAC, University of Canterbury.
[25] K MacFarlane et al. 2011. Tax as a motivating factor to make a quit attempt from smoking: a study before and after the April 2010 tax increase. Journal of Primary Health Care, December 2011.

MŪori, three years for non-MŪori and a two-year reduction in the life expectancy gaps.[26]

The College supports the recommendation of the November 2010 MŪori Affairs Committee report *Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori*, but believes that the recommendations for reducing tobacco consumption in Aotearoa/New Zealand are insufficient in light of tobaccoôs adverse health impacts, as well as the massive relative contribution to health inequities of the tobacco industry. That report recommended the Government aim for tobacco consumption and smoking prevalence to be halved by 2015 across all demographics, followed by a longer-term goal of making New Zealand a smoke-free nation by 2025. The College advocates for more ambitious timeframes, as well as specific targets to reduce the startling differential rates of smoking for MŪori compared to non-MŪori. A study of New Zealand smokers found strong support for increased tobacco control efforts by government and a greater regulation of the tobacco industry, including among MŪori smokers. Those suffering from deprivation and/or financial stress were more likely to support a ban on cigarette sales in 10 yearsôtime.[27]

Smoke-free cars

Smoking in the car continues to be common, particularly among MŪori where nearly a third (30 percent) report others smoke in their car. Not only does this expose others to the health risks of second-hand smoke, it increases the exposure and susceptibility of young people to taking up smoking.[28]

New Zealand and international research shows smoking in cars, even with the windows down, produces dangerous levels of pollutants.[29] A study carried out in 2008 by Thomson et al found almost universal support among smokers for not allowing smoking in cars carrying children. The authors state the results indicated there is strong support across a wide range of smokers, and from the public, for active government intervention to protect New Zealand children from tobacco smoke pollution in cars. Other countries and states (e.g. Australia, Canada and the US) have passed laws to ban smoking in cars carrying children.

The College supports the Government following the lead of other countries by passing legislation to ban smoking in cars that are carrying children. The College also encourages a focus on smoke-free environments across all settings including homes, sports and cultural venues, such as marae, schools, parks and other outdoor settings.

Register of retailers

Licensing tobacco retailers is one of the possible interventions to reduce tobacco supply and improve compliance with the minimum age of purchase law. The introduction of licensing, along with other tobacco control measures, has been

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[26] T Blakely et al. 2011. Inequities in health and the marmot symposia: time for a stocktake. NZMJ, 8 July.
[27] R Edwards et al. 2012. Support for a tobacco endgame and increased regulation of the tobacco industry among New Zealand smokers: results from a National Survey. doi: 10.1136/tobaccocontrol-2011-050324.
[28] The Smokefree Coalition. 2010. Achieving the Vision ï March 2010.
[29] Thomson et al. 2008. Ninety-six percent of New Zealand smokers support smokefree cars containing preschool children. NZMJ Nov 2008. Vol 12 No 1285.

associated with falls in smoking prevalence and uptake in jurisdictions like California. The advantages of licensing have been summarised as:

- reinforcing the understanding that selling tobacco is a privilege, not a right
- providing health authorities with the addresses of sellers, and in the process:
    - facilitating monitoring of their compliance with tobacco control laws
    - enabling authorities to communicate directly with tobacco sellers (i.e. to inform them of changes to the law, etc)
- providing a regulatory mechanism that allows conditions to be placed on the manner in which sales are made and a mechanism by which authority to sell can be revoked.[30]

The College supports the introduction of a tobacco retailer register in line with best practice.

[30] The Smokefree Coalition. 2010. Achieving the Vision ï March 2010